



Medicare Part C Medical Coverage Policy

Dermabrasion

Origination: July 30, 1991
Review Date: July 20, 2022
Next Review: July, 2024

*****This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. *****

DESCRIPTION OF PROCEDURE OR SERVICE

Conventional dermabrasion uses the method of controlled surgical abrasion of the epidermis and superficial dermis with wire brushes, diamond fraise, sandpaper, rasps and burrs. Laser brasion (Tunable Dye, CO² and Ruby lasers) and chemobrasion (phenol, trichloroacetic acid and glycolic acid) are modalities of treatment that are used in place of conventional dermabrasion.

POLICY STATEMENT

Coverage will be provided for dermabrasion when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefits.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC) the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

1. **Preauthorization by the Plan is required;**

AND

2. Ordered by a Physician;

AND

3. Documentation of one of the following:

- a. Correction of defects resulting from traumatic injury, surgery or disease;
- b. A diagnosis of actinic keratosis; **or**
- c. Treatment of rhinophyma in conjunction with antimicrobial therapy

WHEN COVERAGE WILL NOT BE APPROVED

Dermabrasion will not be covered for diagnoses such as:

- Acne and acne scars,
- Reduction of rhytides (skin wrinkles),
- Removal of non-traumatic tattoos (i.e., tattoos of roses, leopards),
- Rosacea other than rhinophyma,
- Smoothing irregularities from traumatic scars,
- Diagnoses that do not support medical necessity because no functional impairment exist.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee that it will be reimbursed.

Applicable codes: 15780, 15781, 15782, 15783

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

References:

1. Medicare National Coverage Determination for Treatment of Actinic Keratosis 250.4. Effective date 11/26/2001): Accessed via Internet site <http://www.cms.gov/viewed> on 06/22/2022.
2. Decision Memo for Actinic Keratoses (CAG-00049N) July 19, 2001; Viewed online at www.cms.gov on 06/22/2022
3. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery – Palmetto GBA Part A/B (L33428) Effective Date 10/01/2015. Accessed via www.cms.gov/ 06/22/2022.
4. Medicare Local Coverage Determination for Cosmetic and Reconstructive Surgery—Wisconsin MAC Part A (L39051) Effective Date: 9/30/2021. Accessed via www.cms.gov on 6/22/2022

Policy Implementation/Update Information:

Revision Date: September 28, 1998; August 17, 2001; October 1, 2001; October 3, 2001; November 8, 2001;

Revision Date: November 14, 2001; June 22, 2005.

Revision Date: February 2007: Clarified conservative treatment modalities; no further criteria changes made.

Revision Date: September 2009: No changes proposed to the review criteria. Formatting and minor wording changes only.

Revision Date: March 2012-Added coverage criteria from LCD L31784.

Revision Date: August 20, 2014; Annual Review; Mirrored NCD and LCD. October 29, 2015 updated LCD due to ICD-10 update only.

Revision Date: August 17, 2016; Annual Review; No Changes to Policy (no CMS changes).

Revision Date: May 16, 2018; Annual Review; No CMS updates. Minor Revisions only.

Revision Date: May 20, 2020; Annual Review; No CMS Updates, Minor Revisions Only.

Revision Date: July 20, 2022: Annual Review; No CMS Updates, Updated to reflect coverage/limitation criteria in LCD L39051

Approval Dates:

Medical Coverage Policy Committee: June 20, 2022

Policy Owner: Beth Sell, RN, BSN
Medical Policy Coordinator